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Debate paper

Closeness equals pathology: working with issues of sexual desire and intimacy within the substance misuse field

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What is known on this subject

- Intimacy and sexual desire are rarely discussed or worked with positively in the substance misuse field.
- Sexual safety and risk reduction are dominant discourses within work with substance misusers and are embedded within particular treatment approaches which pathologise service users' basic needs.
- Exploring intimate relationships is an under-utilised way of engaging service users in effective treatment programmes in substance misuse as well as with other service user groups.

What this paper adds

- It summarises some of the key issues and concerns tied to common discourses around sexual desire and intimacy within the substance misuse field.
- It highlights the essential skills and knowledge that practitioners might need in order to provide more holistic and culturally competent practice.
- It highlights the importance of valuing intimate and social relationships of substance misusers in shaping their engagement with treatment programmes. Adopting a narrative approach is recommended to move beyond assumptions towards respecting human rights and wellbeing.

ABSTRACT

Discourse around desire and intimacy when working with substance misusers is often characterised by issues of social control, repression and silence. It appears that intimacy and sexual desire are rarely discussed or worked with in the substance misuse field and this is potentially an under-researched area of practice within health and social care. Dominant discourse within the substance misusers' field perpetuates a lack of attention to these essential aspects of the human condition.

This paper attempts to raise awareness of these issues and challenges some of the many established assumptions held. It also seeks to identify how practitioners might begin to deconstruct these dominant discourses, and start to recognise issues of intimacy and sexual desire as legitimate needs related to human rights and wellbeing.

While this paper is focused on the substance misuse field, we argue that the concepts raised may be transferable and of interest across the health, social work and social care arena. Exploring these issues within the substance misuse field helps to consider the more general context of why issues of intimacy and sexual desire are neglected in professional practice. Practitioners are challenged to consider how these issues might be enhanced within all aspects of the professional/service user relationship and the essential skills and knowledge required in order to provide more holistic and culturally competent practice.

Keywords: discourse, intimacy, sexual desire, substance misuse

Introduction

There is a dearth of research exploring the issues associated with sexual desire and intimacy within the substance misuse field, in which sexual safety and risk reduction are a major preoccupation for many professionals (Stimson, 1991; Rhodes and Quirk, 1996). The literature available on this topic is scant and this paper is an attempt to summarise some of the key issues and concerns that surround this somewhat taboo topic. An initial analysis and discussion of what might constitute socially embedded meanings tied to common discourses around sexual desire and intimacy within the substance misuse field is provided. Throughout this article the notions of intimacy and sexual desire discussed are inclusive, and are perceived as needs regardless of one's sexual orientation or identity. It is asserted that common treatment models within this specialist area are based on key discourses that underpin traditional substance misuse theory and on which practice depends. These dominant discourses serve to stabilise and embed particular treatment approaches, which in turn marginalise issues concerning normative sexual desire and substance misusers' needs for intimacy and the expression of their sexuality. This will help to provide a more comprehensive and accurate understanding of how and why the holistic needs of substance misusers may be neglected and to suggest more positive potential practice solutions.

Conceptualising substance misuse

Language and definitions of problematic substance use, substance misuse, substance abuse, addiction and dependence vary internationally and across disciplines. Medicine and psychiatry prefer 'addiction' and 'dependence' to encompass either physiological and psychological dependence, or both. The terms 'substance abuse' and 'dependence' continue to reflect the diagnostic criteria set out in the American Psychiatric Association's (2000) *Diagnostic and Statistical Manual of Mental Disorders* (DSM IVR), and the World Health Organization's (1992) *ICD 10 International Classification of Mental and Behavioural Disorders*.

Those working in the field of social work and social care tend to use the term 'substance misuse' to include misuse and dependence on alcohol and/or drugs. Agreement on the correct terminology, however, remains elusive. According to DrugScope, a UK charity providing independent information and expertise on drugs, 'substance misuse', 'addiction' and 'substance abuse' are all culturally constructed labels with negative connotations (DrugScope, 2007). DrugScope argues that 'problematic substance use' is a preferable term to describe service users having difficulty with substances. From now on this paper will use the term 'substance misuse'. This was adopted by the National Treatment Agency (NTA), a UK-based government agency created in 2001 to improve the availability, capacity and effectiveness of treatment for drug misuse. The agency defines substance misuse as:

> The illegal or illicit drug taking or alcohol consumption which leads a person to experience social, psychological, physical or legal problems related to intoxication or regular excessive consumption and/or dependence. Substance misuse therefore is that which causes harm to the individual, their significant others or the wider community (National Treatment Agency, 2002, p.2).

The use of language in connection with substance misuse is indicative of the struggle between practitioners, service users, patients, government, medicine and psychology for authority in theorising about substance misuse and providing treatment solutions. Objective knowing encompasses different trends that have developed from substance misuse studies. These include the *moral model*, in which substance misusers are seen as 'sinful' and 'weak willed' by a society lacking in awareness, the *disease model* (Jellinek, 1960; Rush, undated, cited by Levine, 1978), and *psychological* (Reinout and Stacy, 2005), *social learning* (George, 1989) and *sociocultural models* of understanding (Furnham and Thomson, 1996). The *disease model* has probably been the most significant, taking as its premise the idea of an underlying dysfunctional mechanism in the brain or body (Barber, 2002). This concept underpins the powerful and popular 12-step fellowship programmes, including Alcoholics Anonymous (www.alcoholics-anonymous.org.uk) and Narcotics Anonymous (www. ukna.org). Both have been influential in providing substantial support worldwide. This *disease model* perceives substance misuse as the behavioural consequence of pre-existing and permanent physical vulnerability that 'addicts' have to substances, which fails to regulate drives and contributes to compulsive and perseverant behaviours (Barber, 2002). While some studies have found genetic factors to be at work with regard to substance misuse (Blum *et al*, 1990), this remains highly contentious.

Behavioural learning as an approach emphasises the role people play in participating in the creation of their lives through self-determination, will and rationality. Conceptualising problems in this way emphasises the influence of learning to use substances through personal experience, and the influence of others such as parents, peers, the media or other sources. This model encompasses socio-cultural perspectives, where the use of substances can be seen as helping to alleviate personal and social difficulties by 'self medicating against

life's negative experiences' (Taggart *et al*, 2007, p.360), thus reinforcing substance-misusing behaviour. It has even been argued that consuming drugs is rational in societies where structural and cultural forces promote increasing consumption of goods, to moderate intense emotions and relieve pain and suffering (Elster, 1999; Gray, 2004).

In summary, different conceptualisations of substance misuse subsequently inform how we might work with substance misusers. Many theoretical approaches are informed by practice-based research and experience. Studies involving the use of phenomenological methods reveal the substance misuser's inner experience (Gray, 2004), revealing themes of strong emotions such as suffering, negativity and a personal need for comfort (Banonis, 1989). Considering such themes from the perspective of the substance misuser rather than the practitioner is an important step in dealing with important personal issues. Incompatibility between social, environmental and medical models will always provide a potential barrier to effective holistic practice (Galvani, 2007).

The concept of abstinence

Abstinence from substance misuse is firmly advocated within disease models, while other approaches advocate for the use of harm reduction techniques (Pates, 2002). While abstinence represents the ultimate goal of harm reduction, harm reductionists are more likely to be client centred and work with service users' own defined goals, where reducing substance use is seen as more viable and realistic (McKeganey *et al*, 2004). Interventions to reduce drug-related harm may include needle exchange and substitution therapy such as methadone. Abstinence from both sexual intimacy as well as the misuse of substances is also recommended, especially in early 'recovery' (Peele *et al*, 1991). Long-held beliefs about abstinence and co-dependency within service users' intimate relationships are prominent discourses about substance misuse and sex (Simmons, 2006). These beliefs often make intimacy and sexual desire 'no go' areas for substance misusers, a situation that can be reinforced by practitioners' own approaches and institutional or organisational arrangements within service delivery.

While many individual professionals working with substance misusers in a variety of settings may indeed focus on intimacy and sexual desire, minimal guidance is present within the literature. Where this is addressed, risk narratives prevail (Degenhardt, 2007) at the expense of a more holistic approach to substance misusers' needs within their intimate and personal lives (Jamieson, 1998). Issues of 'sex' addressed in much of the research refer, in the main, to unsafe sex within the substance misuser's own personal relationships (Worth, 1989; Barnard, 1993). There is a preoccupation with sexual abuse and/or the vulnerability of substance misusers to abuse (see, for example, Bollerud, 1990; Berry and Sellman, 2001; Schneider *et al*, 2008). We argue that firm acknowledgement of the central importance of intimacy and sexual desire as aspects of being human can help to create an atmosphere where substance misusers can share the information needed to undertake a thorough assessment and treatment programme. This argument is put forward in a context of increasing interest in sexual politics arising from social movements since the 1960s, which have encouraged citizens to negotiate the sexed aspect of their selves (Dunk, 2007).

Detoxification and residential treatment facilities often fail to recognise the complex interplay between interpersonal dynamics and larger structural dynamics, particularly those barriers in the treatment system that shape the experience of substance misusers (Simmons, 2006). Residential facilities have a number of rules regarding the conduct of the substance misusers during their time in treatment, which usually include bans on all intimate relationships within any programme. Becoming involved with another service user in an intimate or 'inappropriate' relationship is very often a reason for treatment to be terminated (Day *et al*, 2005). Research by Day *et al* (2005) into disciplinary discharge from inpatient services in the UK includes inappropriate relationships as a key reason for such terminations, alongside violence, bringing drugs into the unit, suspicion of drug use, racial or sexist abuse and breaking the ward rules. Skoll (1992), a counsellor and researcher at a residential therapeutic community, makes clear that:

> ... sex and race were never discussed in therapy groups. It was not that sex was never mentioned; but the only reference was to violations of rules that regulated residents' sexual conduct ... Unfortunately, when the residents did begin to talk about sex and race more openly, some residents were put on 'communication bans', and others had their views ridiculed or used as explanations for lack of 'progress in treatment', about which their probation officers were kept well informed (p.10).

Conversely, substance misusers may be seen as 'vulnerable' or 'manipulative' (Simmons, 2006), and research into couples using substance misuse services relies heavily on concepts of co-dependence, dysfunctionality and their roles as protagonists in creating further problems (Rotunda and Doman, 2001). While many intimate relationships that occur in residential facilities may certainly be 'inappropriate' within the context of ensuring safety within the management of a service, assuming pathology akin to other more criminal activities is a telling inference.

The original *Big Book of Alcoholics Anonymous*, written on behalf of the movement in 1939, by Bill

W and Dr Bob, as they are commonly known, may provide us with a better understanding of where this thinking originates from:

> It is only where 'boy meets girl on AA campus', and love follows at first sight, that difficulties may develop. The prospective partners need to be solid AAs and long enough acquainted to know that their compatibility at spiritual, mental, and emotional levels is a fact and not wishful thinking. They need to be sure as possible that no deep-lying emotional handicap in either will be likely to rise up under pressures to cripple them (Step 12) (Alcoholics Anonymous, 1939).

A more modern version of this thinking may underlie rules in many residential treatment programmes, and/or underpin assumptions about substance misusers' inability to have appropriate relationships. In 12 step communities the notion that a couple may get together during treatment or at a 12 step meeting, is often referred to as '13th stepping', which is defined as '*looking to get laid*' (www.urbandictionary.com). Within this historical context, it is understandable that intimacy and sexual desire have become pathologised.

Social relationships remain an underutilised unit of analysis in risk behaviour research (Rhodes and Quirk, 1998) and the active acknowledgement of drug-using and non-drug-using intimate partners is likely to play an important role in determining treatment options and in shaping users' engagement with substance misuse treatment (Simmons, 2006). Skoll (1992) asserts that substance misusers will not shy away from these topics if encouraged to discuss sexual issues in a therapeutic environment. Therefore, one might conclude that not explicitly addressing intimacy and sexual desire within treatment programmes is not only counter-therapeutic but serves to shy away from the broader systems that inform and shape lived experiences of individuals and communities in which human sexuality is imbued with symbolic meaning and social significance (Dunk, 2007). According to Hawkes and Scott (2005, p.7) 'human sexuality is inevitably influenced by a person's social location ... forms of social stratification, relating to class, status, gender, ethnicity, age and so on, [and] will influence modes of individual self-expression' (cited by Dunk, 2007, p.2). Positive consideration of these issues, therefore, can only serve to increase participation and successful engagement of substance misusers within treatment.

Substance misuse policy

Concern about substance misuse and its associated harms has gained considerable political attention and has been subject to extensive policy development internationally (Galvani, 2007; International Drug Policy Consortium, 2007). There has been extensive criticism about the poor retention within substance misuse programmes and their ultimate success. Widespread use of policing, prosecution and punishment of drug users creates a significant burden on public expenditure and, in many countries, is a significant factor in the 'clogging up' of courts and prison systems (International Drug Policy Consortium, 2007). Critiques of UK policy have cited the undue emphasis on increasing the number of people going through treatment programmes rather than on the quality of treatment received despite increasing expenditure in this area (£500 million in 2006–2007) (Batty, 2007). This has sparked a new debate as the UK government consults on a new 10-year strategy (Doward, 2007) with a group of service users who have a range of different problems and lead difficult and chaotic lives (Barber, 2002). The updated Drug Strategy (Home Office, 2002) clearly indicated that women and minority ethnic service users, among other diverse communities, were not well catered for by drug services. Targets were set for improving access to, and providing appropriate services for women, black and minority ethnic communities including gypsies and travellers, asylum seekers and refugees, gay, lesbian, bisexual and transgendered communities and disabled people. A key focus of the new 2008–2018 Drug Strategy is preventing harm to children, young people and families affected by drug use (Home Office, 2008).

Surveys about the factors that influence individuals' choice to use or not use drugs consistently show that risk of arrest and punishment is of only marginal impact, well behind social, cultural and emotional factors (International Drug Policy Consortium, 2007). Equal attention to achieving meaningful personal life in contemporary society is therefore essential to achieving equality for traditionally marginalised groups. Valuing social relationships in which people participate as equals is essential within both personal life and wider social structures that include them. In other words, intimacy across genders, generations, classes and race or ethnicity and culture can only take on this character if the participants can remove such social barriers and transcend structural inequalities (Jamieson, 1998).

Discourses within the substance misuse field

The definitions used and the policy context in the substance misuse field reveal a series of dominant discourses particularly in therapy and treatment models which tend to marginalise issues emerging from any

discussion about intimacy and sexual desire. Discourse is a taken-for-granted sense of belief that escapes critical scrutiny (Foucault, 1994). This can serve to marginalise and obscure other ways of seeing the world building on a modernist approach in which a sense of security and order can be derived from reducing all phenomena to a series of logical formulae. Traditional substance misuse theory and practice depend on, and uphold, the beliefs they have created and tend to reflect the interests and moral standards of dominant groups in society.

Taleff and Babcock (1998) identify several such dominant discourses in substance misuse work. We will refer to those that we feel are related to the central issues being explored here in relation to the inclusion of issues of intimacy and sexual desire in substance misuse treatment. We argue that such discourses can prevent practitioners from developing a sense of openness, curiosity and critical practice in this area. By not asking the more difficult questions that essentially challenge these assumptions, practitioners may be doing substance misusers a huge disservice.

The 'blame game' within substance misuse services

One of the many challenges in the substance misuse field is the notion of 'engagement' of substance misusers with the help and support available, and a need to avoid relapse (Barber, 1995). The idea of substance misusers' failure to engage with services builds on the belief that predetermined factors within the individuals' personality, characteristics associated with diversity or forces of compulsion and addiction history prevent them from being successful (Taleff and Babcock, 1998). This detracts critical attention away from the shortcomings of interventions themselves, by failing to critically examine the complex environmental factors contributing to users' individual problems (Chiauzzi, 1991).

Treatment approaches, including motivational interviewing, have tried to address this 'one size fits all' mentality within the substance misuse field (Taggart *et al*, 2007), and allow 'more room' in which to discuss issues of intimacy and sexual desire. The notion of 'novice recovery' (Walters, 1996) can go unrecognised, where falling short of completing a treatment programme is viewed as a failure, thus effectively blocking any new creative means of responding to relapse. One example of this is in working with women in the substance misuse field. Sexuality is often one of the rawest areas for a recovering woman's self-esteem, especially where substance misuse may have been used to disguise sexual problems (Kirkpatrick, 1977). Gender stereotyping and the impact of gender discrimination within assessment and service provision may lead to a woman's own need for support and intimacy being neglected or forgotten (Jamieson, 1998). Practitioners could facilitate women's insight into this, which involves more than merely reshaping substance misuse habits. Further exploration should lead us to consider that there is more to recovery than just abstinence and more to sexuality than just sex (Kirkpatrick, 1977). The implications for service delivery assert the need for women-only spaces and an approach that enables women to examine issues around intimacy as critical to self-recovery (Women for Sobriety, 2007).

One can easily transfer these principles to other marginalised groups, for example the provision of treatment to black and minority ethnic communities. Ethnicity and culture are not single dimensions of experience but a composite of identity, beliefs, expectations, cultural beliefs, history and language (National Treatment Agency, 2003). Competence in working with those who misuse substances must include the purchasing and provision of services that are able to work with culturally specific issues of sexual desire and intimacy rather than continuing to couch these in vague terms.

Co-dependency issues

Co-dependency theory refers to the idea that people misusing substances may come from dysfunctional families that unwittingly contribute to the perpetration of the substance misuser's destructive behaviour (Cermak, 1986). Critiques of this theory have observed that many of the behaviours described as co-dependent are behaviours traditionally ascribed to women, who, more so than men, think of close relationships and caring for others as healthy, adaptive, and integral to their wellbeing (Corby and Millar, 1998). It is what Taleff and Babcock (1998, p.36) refer to as 'closeness equals pathology'. Here the notion of closeness is perceived as a sickness generating a fear of closeness or co-dependency, where the significant others of substance misusers are too closely involved in the dynamics of the addiction, to the point of conspiracy. From this viewpoint, any love, anxiety, cultural closeness and feminine nurturing are derogated (Simmons and Singer, 2006).

The idea of valuing total independence and autonomy also fails to recognise the need for healthy interdependence (Taleff and Babcock, 1998). Further understanding of the complex interpersonal dynamics between drug-using couples has not, as yet, been tapped for its potential to shape prevention and intervention efforts that would reduce drug use and other associated risks (Simmons and Singer, 2006). Some research into couples using heroin and cocaine have utilised intimate partnerships as a unit of analysis, in which they seek to challenge couples as mere sex

partners, 'running buddies' or 'drug associates' (Simmons, 2006; Simmons and Singer, 2006).

Taking a different view of substance misusers as spouses, lovers or intimate partners in committed relationships allows us to work with their struggles and aspirations for other social norms, such as love, fidelity, material and emotional support (Simmons and Singer, 2006, p.7). Simmons and Singer's analysis of the 'care and collusion' binaries commonly found within substance misusers' intimate relationships emphasises the importance of recognising the existence and importance of interpersonal dynamics. Working with both partners was crucial to co-ordinating detoxification and treatment and in orientating practitioners to couples' integrated needs within a comprehensive system of treatment. This is not to deny the very real risks and dangers that can be inherent when both partners are misusing substances, but seeks to offer alternative explanations of relationship dynamics. Further research into the peer injecting of illicit drugs into women by their male intimate partners found that working to enhance women's motivation to effect change in an abusive situation is equally important as dealing with the physical, economic and emotional abuse from their male partners (Wright *et al*, 2007).

Families have a key role to play in terms of positively influencing the course of the substance misuse problem and improving treatment outcomes for the substance misuser (Copello *et al*, 2005). Family members can help to engage the substance misuser in treatment and become a constructive part of the treatment process. Some substance misuse treatment services, for example Clouds House in the UK, provide services for family members, and even offer short-stay residential services, alongside services for the substance misuser (www.actiononaddiction.org.uk/treatment/clouds_house/). This is an area where further research could provide us with more understanding of the services currently being provided to substance misusers and their networks.

Drugalities

Moore's (2004) work regarding drugalities can help in further exploring assumptions relating to the nature of different drugs in relation to issues of sex, intimacy and desire:

> Drugalities are like personalities ... Drugs have never been physical entities. Reactions to drugs come as much from understandings (or alleged understandings) of their social presence as from understanding (or, again alleged understandings) of their pharmacologies (p.420).

Moore (2004) argues that substances, through their drugalities, are racialised, gendered and related to class. For example, assumptions relating to heroin and cocaine come not only from their pharmacological actions, but also from the actions to which they are culturally ascribed. Heroin in the UK may be seen as primarily a white working class problem, strongly related to criminal behaviour and the HIV epidemic. Likewise, recreational cocaine may be glamorised and primarily associated with celebrities and middle class professions (Seigal, 1984), while drugs like ecstasy are described as dance drugs and are associated with the club culture (Slevin, 2004). Crack, on the other hand, has associations with deprived black communities, and a chaotic instability born out of the short-lived high that is provided by the drug (Moore, 2004).

The inclusion of issues relating to intimacy and sexual desire within the concept of drugality can enable us to examine other assumptions. Several are noted in relation to crack use. The idea of the 'crack whore' as a woman willing to do whatever necessary for her next rock is as invasive as the idea of the 'crack baby', and both have huge implications for how women, and specifically black women and mothers, are even further marginalised (Moore, 2004).

Research into the similarities and differences between the use of particular drugs among gay, bisexual and heterosexual persons, particularly on the clubbing scene, has not drawn any conclusions, although many stereotypes have been drawn about the former group (Degenhardt, 2007). Gay men's use of certain types of drugs is also often associated with sex – the act itself as well as sexual desire. Slevin's (2004) ethnographic account of a night out at a gay nightclub in Sydney, Australia, describes 'a gay nightlife scene in which illicit drugs are common and normalised' (p.268). This account articulates clear links in this particular community between drugs, especially crystal methamphetamine, and sexual desire, referred to as 'chem sex' (Slevin, 2004, p.274). These drugalities, alongside users' narratives, clearly show how society might view different types of substance misusers, and in turn the association with intimacy and sexual desire. There are clearly a number of stereotypes and assumptions that can easily lead to discrimination against drug users, whether they are black women who use crack, or gay men who might use crystal methamphetamine to enhance their sexual experiences. Given these stereotypes and assumptions, it would appear vital not only to discuss sexual safety within substance misuse treatment programmes, but also to consider how intimacy and sexual desire can be positively addressed.

The challenge for effective practice

This discussion reveals how easy it is to cultivate negative views of intimacy and sexual desire within

professional practice or to dismiss them altogether. Given this scenario, we now turn to consider what might constitute more appropriate responses and how practitioners might begin to look at how the issues of intimacy and sexual desire might be reconfigured in a more positive way.

Health and social care practitioners may lack confidence in this area of practice, particularly as they find themselves dealing with very complex issues associated with a range of service user groups. Where substance misuse may not be an area of expertise, professionals may find themselves without the prerequisite knowledge and skills base to work confidently or effectively. Goodman (2007, p.2) highlights the multiplicity of concerns, including relationship issues, that substance misusers experience. Financial problems, housing, risk of offending, physical and mental ill-heath, behavioural issues such as anger and aggression all require professionals to pay close attention to their own values and ethics. Substance misusers need support and encouragement to gain or regain control of their lives with a range of responses that will include additional assessment, resources and interventions that help to modify and maintain their lifestyle (Goodman, 2007, p.6). Within the varying problems that substance users often present, it is easy to see why issues of intimacy and sexual desire may be sidelined. The essence of work in this area needs to involve constructing, 'deconstructing' and 'reconstructing' many of the theoretical models commonly used by practitioners, by linking substance misusers' problems to the social, cultural and political context in which they arise (Thompson, 2003; Rhodes and Quirk, 1998). This work requires a different type of engagement with substance misusers.

Substance misusers are often irritated by certain aspects of treatment programmes that they do not understand, or by staff who are disrespectful (Fischer *et al*, 2007). Professionals should be prepared to listen to clients and take account of the regulatory effects of approaches to substance misuse treatment that can prevent the creation of innovative cultures of care. An important issue for professional practitioners is the redefining of substance misuse as a social and interpersonal issue rather than just a health or criminal justice problem (Race, 2007). There has been a growing knowledge base in the area of sexuality within health and social care (Cosis-Brown, 1998; Fish, 2006; Myers and Milner, 2007) and around the relationships between the mind and the body (Twigg, 2006). There have also been significant developments in professional knowledge alongside service user knowledge and control in the substance misuse field (McCarthy and Galvani, 2004). These developments can provide a more sophisticated approach to helping that does not ignore the inevitable difficulties inherent in the complexity of problems faced by substance misusers and their supporters.

More debate is needed on how these practice ideas might work in other settings where intimacy and sexual desire are often neglected as other more pressing concerns come first, for example in the area of safeguarding practice, or domestic violence (Hayden, 2004). Borochowitz's (2002) research aimed at describing and analysing the strategies for reconciling love and violence in intimate relationships recognises the negative assumptions made about violent intimate relationships, but concludes that feelings of love can and do exist in violent relationships. Achieving safety and control for service users in this scenario may require the avoidance of pathologising or misinterpreting feelings in order to avoid the risk of disengaging victims of domestic violence and supporting them to act, just as we might substance misusers.

Many contradictions need to be reconciled. According to the Declaration of Sexual Rights (World Association for Sexual Health, 2006), service users have the right to sexual autonomy, sexual integrity and safety of the sexual body as well as sexual pleasure as a source of physical, intellectual, and spiritual wellbeing. Likewise, Article 8 of the Human Rights Act provides that the right to respect for private and family life, home and correspondence, should be actively considered in the design and delivery of any health and social care services. Engagement in reflective practice enables practitioners working with substance misusers to influence the ways in which issues of intimacy and sexual desire are constructed, by actively engaging in some of the discourses outlined earlier in this paper. By developing our potential to challenge and transform taken-for-granted interventions and responses, we can offer substance misusers a more holistic approach to the myriad complex issues they may present with. This has to include an awareness of our own needs for intimacy and acknowledgement of our own sexual desires, alongside the organisational context for practice, in order to be open and sensitive to the sexual issues of clients (Bywater and Jones, 2007). Talking about intimacy and sexual desire can be difficult, so developing sensitive language and listening skills to enable substance misusers to express their own doubts, anxieties and problems is essential. Reflexive practice can foster skills and knowledge to encourage a sense of openness, curiosity and critical practice. Enabling practitioners to feel comfortable about asking clients about intimacy and sexuality is an essential part of professional education and practice. Working in this way with substance misusers avoids pathologising what is a basic human need.

Much of the literature within health and social care has been primarily concerned with either specifically defined, marginalised or minority groups and issues of sexual identity. Less attention is given to everyday sexuality in terms of the ways in which all service users, regardless of sexual identity, can be helped to

individually construct and negotiate their sexuality in relation to intimacy and sexual desire:

> Compartmentalising sexuality into specialised areas of practice has acted to eclipse the need for sexuality to be approached as an everyday characteristic of the self. Were sexuality to be seen as a human attribute, it would therefore be of central concern to a profession whose work centres around people (Dunk, 2007, p.138).

Conceptualising sexuality as another key aspect of identity, as culture, provides the context within which a move towards cultural competence can be achieved. Cultural sensitivity is a prerequisite to professional competence, and the cultural competence continuum includes being culturally sensitive, culturally specific, culturally congruent and culturally appropriate. Dunk (2007) recommends the assimilation of the PLISSIT model into mainstream care work. This model was originally developed for use by general practitioners (GPs) to conceptualise patients' concerns about sexuality. PLISSIT is an acronym for permission (P), limited information (LI) specific suggestions (SS) and intensive therapy (IT); each element represents a level at which substance misusers' needs might be accommodated (Dunk, 2007, p.140). At the P and LI levels, the practitioner is perceived as someone to whom the substance misuser can talk in an everyday manner about issues related to intimacy and sexual desire; the practitioner is able to respond confidently. At the SS and IT levels, attention is focused on determining the most appropriate course of action. This may include making specific specialist referrals. The PLISSIT model can help practitioners to consider the oppressions that people have been subject to by their social status because of substance misuse, race, gender and class. Both narrative and solution-focused therapies facilitate the search to understand substance misusers as individuals with unique experiences, strengths and solutions to their current difficulties (Myers and Milner, 2007). Adopting a narrative approach engages with and moves beyond the challenges offered by dominant explanations and discourses towards engagement with substance misusers as complex individuals.

Conclusion

This paper has presented a discussion of the more dominant discourses about substance misusers and the assumptions underpinning the conceptualisation of their need for intimacy and sexual desire within treatment systems. Analysing intimacy and sexual desire in this way allows us to understand more meaningfully how the needs of substance misusers to express intimacy and sexual desire have been neglected or misunderstood. We have asserted that attention to these issues is central to respecting human rights and wellbeing. Responding to these issues is complex, but should alert us to the potential for increased choice, change and diversity within the substance misuse field. Learning from substance misusers themselves can be a major source of expertise and knowledge if we are not afraid to ask.

Finally, we conclude that the possibilities of cultural influences in reframing practice can be enhanced. Attention to the learning and development needs of practitioners and effective working practices can ascertain the knowledge and skills required to work with individuals and partners in this area. The use of guidelines and protocols that explicitly include intimacy and desire, such as those based on the PLISSIT model as suggested by Dunk (2007), is recommended. Finally, the use of ethnographic perspectives can throw light on cultural variations in the meaning of intimacy and sexual desire in the already complicated lives of substance misusers.

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